DELINEATION OF CLINICAL PRIVILEGES - PULMONARY DISEASE

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Clinical privileges in this specialty include the diagnosis, evaluation, prevention, and treatment of diseases in adult and adolescent patients as in internal medicine, with special expertise in the areas of pulmonary disease. The following list of diagnostic and therapeutic modalities exemplifies the various areas of the subspecialty, but is neither inclusive nor exclusive.

NOTE: This document is to be used in conjunction with DA Form 5440-3, Delineation of Clinical Privileges - Internal Medicine.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Requested	Approved		Requested	Approved	
		a. Tube thoracostomy			o. Pericardiocentesis
		b. Diagnostic bronchoscopy			p. Thoracentesis
		c. Interventional bronchoscopy			q. Arthrocentesis
		d. Bronchial brushing			r. Bone marrow aspiration
		e. Bronchial lavage			s. Bone marrow biopsy
		f. Bronchograms			t. Arterial puncture and cannulation
		g. Diagnostic and interventional laryngoscopy			u. Central venous puncture *(including subclavian, internal jugular, and femoral sites)*
		h. Transthoracic needle lung aspiration and biopsy			v. Pulmonary artery catheterization
		i. Pleural biopsy *(closed)*			w. Endotracheal intubation
		j. Transtracheal aspiration			x. Respirator management
		k. Percutaneous tracheostomy			y. Elective cardioversion
		l. Bronchoprovocation challenge			z. Cardiac pacemaker insertion
		m. Interpretation of:			aa. Spinal tap
		(1) Pulmonary function testing			ab. Administration of conscious sedation
		(2) Cardiopulmonary exercise testing			ac. Whole lung lavage under general anesthesia
		(3) Electrocardiograms			
		(4) Polysomnograms			
		n. Paracentesis			

LASER PRIVILEGES

Requests for laser privileges may require attendance at a formal laser training program(s), supporting documentation of training, experience, etc., acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibility for laser therapy. The necessary documentation in support of this request is attached.

Requested	Approved		Requested	Approved	
		a. YAG laser ablation via bronchoscopy			
		b. Photodynamic laser therapy			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - PULMONARY DISEASE

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Tube thoracostomy			
	b. Diagnostic bronchoscopy			
	c. Interventional bronchoscopy			
	d. Bronchial brushing			
	e. Bronchial lavage			
	f. Bronchograms			
	g. Diagnostic and interventional laryngoscopy			
	h. Transthoracic needle lung aspiration and biopsy			
	i. Pleural biopsy *(closed)*			
	j. Transtracheal aspiration			
	k. Percutaneous tracheostomy			
	l. Bronchoprovocation challenge			
	m. Interpretation of:			
	(1) Pulmonary function testing			
	(2) Cardiopulmonary exercise testing			
	(3) Electrocardiograms			
	(4) Polysomnograms			
	n. Paracentesis			
	o. Pericardiocentesis			
	p. Thoracentesis			
	q. Arthrocentesis			
	r. Bone marrow aspiration			
	s. Bone marrow biopsy			
	t. Arterial puncture and cannulation			
	u. Central venous puncture *(including subclavian, internal jugular, and femoral sites)*			
	v. Pulmonary artery catheterization			
	w. Endotracheal intubation			
	x. Respirator management			
	y. Elective cardioversion			
	z. Cardiac pacemaker insertion			
	aa. Spinal tap			
	ab. Administration of conscious sedation			
	ac. Whole lung lavage under general anesthesia			

CODE	LASER PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. YAG laser ablation via bronchoscopy			
	b. Photodynamic laser therapy			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*